Discussion of Ideologies Underlying Inter-professional Health Education in the Ontario, Canada Context

Peggy M. O'Neil
Faculty of Education, The University of Western Ontario, Canada

Abstract

Recently, there has been significant interest in a specialized inter-disciplinary movement in healthcare called inter-professional education and practice (IPE/P). Health policy-makers and education programmers are beginning to adopt and fund its concepts. A review of extant literature reveals that most contributors to this initiative belong to the health professions while formal education scholars and their full spectrum of approaches and methods are not yet apparent. This paper provides a review of pertinent IPE/P literature and offers an introductory commentary and appraisal drawing on education's Humanities lenses, specifically philosophic inquiry. The paper concludes with a sketch outlining the merits and instrumentality of pursuing a philosophy for IPE/P.

1. Introduction

In Canada and Ontario, healthcare is one of the most prominent aspects of public policy, directed at caring for people across their life spans. Much has been written and debated on the subject. What is it? Who should deliver it? Where is the best place to deliver it and in what way? How will we know if we are doing a good job? How are things prevented from going wrong, and what happens if they do? Behind these ostensibly innocuous questions reside many complexities such as democracy, human rights, justice, morality, ethics, equality, freedom and more. Policy-makers, governing bodies, health executives, practitioners and consumers grapple with the "right" thing to do and how to proceed.

In recent years, each decade has presented/revived distinct concepts as means toward important ends in healthcare. In the 1990's patient-centred care (PCC) emerged. It held that care should originate from the patient and not the provider. In the 2000's evidence-based clinical practice (EBCP) arrived, insisting that practitioners apply published findings in their work in order to minimize avoidable errors or oversights across the care continuum. While I would argue that PCC and EBCP are not yet fully implemented across hospitals and health agencies for various political and practical reasons, another concept to be implemented has emerged. Inter-professional education (IPE) and practice (IPP) arrives with an optimism that it will improve the overall quality of healthcare [1],[3],[5],[29]. A cursory scan of websites from Canadian universities which deliver health education programs shows that almost all have an IPE presence. Some schools have offices which promote the concept, offer courses and coordinate student placements and others simply state it is a value of the institution.

In terms of their life-cycle, IPE and IPP are in the early adoption phase, not yet fully institutionalized in schools or practice settings. Given the significant impact of IPE education programs in their preparation and development of the next generation of health care workforce, it behooves the academic and practice communities to attempt to advance a robust approach to this movement. Reeves [29] and Clark [5] have put forward a call for more theory and evaluation of IPE. This paper provides some initial musings on a tentative response only to IPE and IPP ontology and epistemology, reasoning that until the construct is fully conceptualized and implemented, it is too soon to embark upon evaluation discourse. In this view, I first present a brief overview of the current IPE literature that presently represents and informs this phenomenon. Next, I offer some perspectives for further reflection and research in IPE. Lastly, I outline a potential approach for additional inquiry with the intention of continued discussion toward potentially favorable education programs, practice, and research across various health settings.

2. Overview of current IPE/P literature

To inform this section of the paper, I conducted a structured literature search of various databases. I filtered the results for articles only relating to the conceptual, theoretical or substantive nature of IPE. Publications relating to evaluation or program-specific experiences such as those addressing cancer care IPE placements were not included as these hold too narrow a focus for my present work. Next, I cross-referenced bibliographies from the selected sources to ensure that influential, highly referenced citations were included.

A review of these references reveals that there have been several iterations of terms pre-dating

"inter-professional" including inter-disciplinary [7], pan-professional [13], and multi-professional [19], [27]. Although some use them interchangeably, a few have argued for a clear distinction [10]. Presently, the term inter-professional is the most widely adopted. For the most part, the definition advanced by the Centre for Advancement of Inter-professional Education is generally accepted, *"…occasions when two or more professions learn together with the object of cultivating collaborative practice'*[3]. While this is a somewhat sweeping definition, and collaborative practice itself could benefit from further clarification, it appears to be nevertheless a broad enough account to apply to most settings. Further, the definition of IPE has not been identified in the literature as an area of concern as most commentators are preoccupied with current theoretical stance of IPE.

At present, the theoretical foundations of IPE are largely descriptive [5], [29] anecdotal and atheoretical [5]. However, recently, a few scholars have synthesized the literature on IPE [5], [7], [28], [34], [35] and some have attempted to offer initial frameworks [19]. Clark et al [6] have introduced a discussion on the ethical implications of IPE and respective practical problems that could emerge in settings where teams are accountable instead of individuals each functioning in their respective professions. Beyond this, though, IPE seems to be approached as a positive good instead of situated in the existing policy, legal and political context. Reeves [29] suggests that another step in advancing IPE will be to further investigate sociological theories that explore power and legitimacy which might enable IPE participants to explore some of the taken-for-granted assumptions in the field. Additionally, there are a few notations that a bridge between IPE and IPP would be helpful [5], [10], [29], however there does not at this time appear to be a strong argument for or against considering them collectively or separately.

The skills noted in the literature (and so presumably the basis for academic programming and curriculum development) are varied yet seem to largely draw on organizational literature. There have been a few attempts to conceptualize or advance frameworks or hierarchies for the following organizational constructs within IPE: organizational change [17]; teamwork / working together / collaboration [10], [11], [18], [29], [6] and shared decision-making [22]. The Canadian Inter - professional Health Collaborative has engaged in an analysis of various models of competencies and has published these, which refine and expand on the skills mentioned already.

In terms of specific methods and approaches to teaching and learning in IPE, several theories and models of education are cited in the literature. Some of these learning theories include Knowles' [20] adult education principles [4],[29]; Schon's [30], [31] reflective practice [5], Barrows & Tamblyn's [2] problem-based learning [5] and Kolb's [31] experiential learning [5],[11]. While these methods and approaches may be in alignment with the tenets and goals of IPE there is not yet explicit agreement or argument in the literature as to why these should be used over other means, nor is there a rationale as to these will achieve the education outcomes desired. Education as an area of study has an inter-disciplinary heritage, drawing on the Social Sciences such as Psychology, Sociology, and Economics as well as the Humanities including Philosophy, Law, and the Arts. It appears that to date IPE draws almost exclusively on education's Social Sciences foundations and so far overlooks the instrumentality of its Humanities theories and methods. This may prove problematic over time in that the exclusive use of psycho-social models elevates their ontologies and epistemologies over those of other health professions. Additionally, it may prove useful to apply Humanities lenses for an exterior view of the phenomenon.

In general, the summative and analytic literature to date offer many insights into the historical and emerging theoretical context for IPE, however it is apparent that more work is needed, as has been mentioned by many current contributors. Even so, many schools have officially sanctioned IPE programs, have received funding and in some cases offer classes based on some curriculum. This being said, many of these programs are voluntary and are electives outside the standard curricula. Foundational academic programming change does not appear to have occurred in Ontario in schools delivering health education programs.

3. Further reflections on advancing IPE and IPP

Although this paper represents only an initial scan of the IPE literature and additional inquiry would reveal more, preliminarily there seem to me to be four further points to consider in this movement's evolution: 1) IPE and IPP may inseparable for several policy and practical reasons; 2) teaching and learning in health professions is not limited to education institutions and may indeed be component parts of practice; 3) some aspects of health practice may be "out of bounds" for team-based decision making; and, 4) organizational literature based essentially on interpersonal skills may not be commensurate for the almost daunting task of developing education and practice programs in pursuit of quality health care. I will offer some introductory musings on these points in the spirit of initiating reflection and further discussion.

3.1. Inherent connectivity in health policy, education and practice

The Ontario health policy setting and respective education and practice contexts is very complex, yet very interrelated. In the mid 1990's the province of Ontario officially sanctioned government administered regulatory bodies for twenty three health professions. In many ways, these bodies are more senior than either education institutions or practice settings. Indeed, several of them comment on accountabilities based on status within the profession. For example, the College of Nurses of Ontario sets parameters for members participating in leadership, education, practice and also provides direction of the supervision of students. While schools can set their own curricula and health agencies such as hospitals and family health teams can establish their own corporate values, policies and practices, provincial colleges' activities and respective legislation can take precedence. For example, the College of Respiratory Therapists (RT) instituted an exam at five year intervals for their members. After the college's inception during the first wave of exams, few RT members were able to pass it. Employers could not allow their RTs to continue to work. Ontario employers, unions and members worked with the College to find a solution. Similarly, the College of Nurses of Ontario dictated that Registered Nurse status as of 1995 required a university degree and community college programs were left to find solutions, hence the collaborative nursing programs in existence today such as the University of Western Ontario and Fanshawe College program. The provincial colleges have a lot of power in determining education and practice in the health professions. Advancing only IPE without IPP creates some difficulties in terms of coherence across the spectrum of the health policy, education and practice context.

Another policy factor suggesting IPE and IPP are inseparable is the relationship between education institutions and placement settings with regard to school accreditation processes and school-clinical setting education affiliation arrangements. Most students in health education programs require field/practical/clinical placements in order graduate. As such, school accrediting bodies surveying affiliated placement settings in their assessments and subsequent status awards. Additionally, most schools and placement settings have affiliation agreements that outline legal roles and responsibilities of each party. Often, the school must inform the placement settings of any major academic changes, such as mandatory adoption of IPE. Should schools adopt IPE approaches without concurrent advancement in practice settings, it could become problematic to: 1) find suitable placements/placement supervision for students educated in IPE context(placement settings can and do accept or reject students based on the school and expectations of preparation of students for placements; 2) appear legitimate to students whose didactic experience may not match the real world; and 3) convince employers not espousing IPE tenets that school graduates are worthy candidates for employment at their institutions. On the other hand, placement agencies/ employers not espousing IPP may be viewed by students as undesirable work settings, causing further employer frustration in recruiting and retaining professions where labour shortages exist.

All of this being said, health policy, education and practice is an iterative endeavour in that provincial regulatory bodies generally don't exist in the metaphorical ivory tower. They draw on advancements from their members in academic communities, practitioners and sometimes unions. Selecting out IPE is very definitely a good point of departure, however widespread policy, practice and education change will not occur in my view, without also including IPP.

3.2. Inherent teaching and learning functions in health practice

In my 22 years in healthcare many of which spent in education policy and library services, I have come to believe that professional practice is almost indistinguishable from education (teaching and learning). Generally, professions have in place 1) a defined path into the profession, drawing on specialized literature, devices and methods, 2) an entrance criteria for professional certification, 3) quality assurance programs to ensure life-long learning within the discipline, 4) ways and means to foster the next generation and 5) expectations for the advancement of knowledge within the field. From years of observation, my colleagues and I advanced a concept of health professional practice which supposes that care, teaching/learning and research/inquiry are component parts of practice and inextricably connected. The scale of these activities could reasonably be comparable to one's level of expertise, broadly defined by Dreyfus' [12] model of skill acquisition which has been sanctioned for some time across the health professions. So, for example, a new dietitian caring for a person in need of a nasal-gastro feeding tube, might read (learn) the literature relating to this type of feeding and may also look into (research) which companies provide such a feeding system. Whereas, an expert dietitian might publish (teach) on the effects of such a feeding system and its limits in the care of post-chemotherapy cancer patients; and may conduct research to find out if Vitamin supplements in conjunction with the feeding system may better sustain the gut in order to improve nutrient

absorption. Here, one can observe that forms of teaching and learning are required in practice.

Further, life-long learning and remaining current in one's field are requirements for competent practice. The publication rate of health literature and ensuing "best practices" are not stable. New studies and drug recalls can affect/effect practice very quickly. Practice standards in most provincial regulatory bodies mention the use of evidence. The policy and practice position for the use of learning from evidence is apparent. Here again, I suggest that IPE cannot be separated from IPP and both need to be included moving forward.

4. Distinguishing boundaries: What teams can't do

Reeves [29] comments on the taken-for-granted aspects of IPE and Clark [5] suggests that there are "technical" and "aesthetic" aspects to life in the health professions. I agree. It seems that one of the criticisms of inter-disciplinary endeavours is the depth/breadth combination. The emphasis between specialization and generalization seem to vacillate across education settings over time. As a hybrid in this context, I would like to introduce for discussion the notion that the technical aspects of health professions such as their literature base, assistive devices, technologies, specialized methods are best addressed through specialization and so fall outside the of scope of IPE/P. Further, these seem to me to be factors not up for discussion by IPE team processes and constitute examples where teams do not have jurisdiction to overrule. This point may appear simple and obvious, though it can be laden with difficulties. It is possible that ontologically and epistemologically different fields such as medical laboratory science and social work may have conflicting evidence on the "best" way to proceed with care. How do such matters get resolved? How does each practitioner maintain professional standards and ethics? It may not be "fair" that the most compelling evidence prevail. For example, medicine traditionally has more funding, more access to publications more people practicing in the field than speech language pathologists (SLP). One significant study in SLP may be more important than six studies in medicine given the individual case, the context and the circumstances. How do teams resolve this? Could there be professional implications for the SLP who succumbed to team decision-making? Teamwork literature may not be conceptually robust enough to manage situations such as these. I support further inquiry into Clark's [6] ethical considerations for IPE/P

Perhaps the only legitimate realm for more generalized programming for IPE/P is the not yet well defined "aesthetic" aspects of practice, which go beyond *skills*. These may situate naturally within the Humanities such as ethics, concepts of justice, morality, fairness, freedom, democracy, the nature of mankind and others. Accordingly, it is conceivable that a version of "common curriculum" could be established for students from various health professions.

While the patient-centred care and evidence-based practice movements could be accommodated through content-based integration into existing academic programs, IPE/P does not lend itself to such approaches. Administering admissions, facilities, program planning, scheduling, funding, instructor recruitment and development, curriculum, evaluation among other factors present opportunities and challenges in fully implementing IPE/P.

4. 1. Substantive and Conceptual Incommensurability of organizational literature

While organizational behavior and organizational development literature offer some basis for moving forward in IPE/P, it seems to be somewhat lacking in its origins, and foundations. Largely, this literature emerges from the business context and sometimes from the popular press. While I have used these concepts, for me, the applied scope of IPE/P expands beyond the boundaries of organizational setting and so its literature. Health professionals function in extra-intra-organizational contexts with multiple participants and varying voices such as public policy processes and continuum of care bed management spanning several organizations and agencies. Which team is one on at any given time? The provincial team of nurses? The health agency's? The unit on which one works? Ideally the goals of all of these align, however in instances of incongruence, which is senior and where is one's duty and allegiance---are these the same?

Teams also imply that consensus can be achieved. While in most cases I suspect this is so, in contentious, complex cases power and value struggles can render these ideals unworkable in addition to the conceptual divergence between professions. Yet, decisions must be made as health professionals are charged with taking action. Perhaps theoretical approaches in health justice and/or democracy might prove more fruitful. Justice and democracy models such as Sen [32] and Daniels [8] acknowledge the uneven distribution of power, yet offer ways and means to nevertheless move forward. Further, requirements for public scrutiny and moral obligations are embedded in ideas of democracy and are not explicit in teams.

5. Why an integrated philosophy of IPE and IPP

Given the discussion up to this point, it may be too soon to advance *a* theory of IPE/P. Such might prove too narrow to fundamentally shift policy or to be embedded in curricula and practice settings. While the IPE/P literature to date is useful in naming the phenomenon and some of its goals and in beginning to characterize the IPE/P movement, broader aspirations and methods are worth pursuing. Instead of a theory, I propose that a philosophy of IPE/P is warranted. An education philosophy would have more resilience in what could be considered a tumultuous environment where stimuli for change (SARS, privacy legislation, world-first studies) are commonplace. A philosophy built on a sound framework could assist policy makers with a comprehensive, coherent structure to bind otherwise apparently random aspects within policy documents and credentialing processes. It could provide schools with a starting point of ends and means by which curricula design, the selection of teaching methods and program/course/student evaluation could begin. In the clinical setting, a philosophy of IPE/P could provide a point of departure for practice leaders to frame development programs, the organization of work, and human resources activities.

In a later endeavor, I plan to apply Frankena's [15] model for analyzing and developing a philosophy of education to the IPE/P context. He offers a scheme for relating and evaluating content and arguments within education (teaching and learning) aspirations. Initially the bases and coherence of *dispositions* or *virtues* that the education should foster are located along with their normative and empirical premises. Next, the ways and means (instructional methods) for achieving the important ends are isolated with supporting perspectives. The objectives of such inquiry would not be simply to sift and sort existing IPE/P contributions rather to also respond analytically to the current offerings in the literature and to respond systematically to what has been put forward as legitimate/reasonable means. Alignment would be an important factor. While adult learning and experiential learning might survive as tactics to achieve IPE/P, on their own they may not be sustainable in a philosophic discussion. It is possible that structures for justice (philosophic not social necessarily) warrant discussion across the continuum of IPE/P policy, education and practice settings, where transparency and public scrutiny are important. I have for some time believed that Etienne Wenger's [33] communities of practice work has been overlooked in healthcare and may have some merit here in terms of a more robust learning stance better suited to the objectives of IPE/P. Similarly, "reflective practice" might better be conceptualized philosophically, drawing on Elgin's [14] work on the iterative judgment process groups embark upon in evolving their structures and tenets. At this point, these are musings as the application of the model to the context would surface the merits and limits of these initial suggestions.

Healthcare and its foundational education structures have been very important to me and I have dedicated many years of service to this field. Now, I believe there is a timely opportunity for education as an area of study to contribute something important to IPE/P. Bringing wider education scholarship, and particularly its Humanities traditions, to the present dialogue could advance the movement toward its broader ideals of quality care and sustainable, responsive health care systems.

6. References

[1] Barr, H., Hammick, M., Koppel, I., Reeves, S. (1999). Evaluating Interprofessional Education: two systematic reviews for health and social care. *British Educational Research Journal*, 25(4), 533-544.

[2] Barrows, H.S. & Tamblyn, R.M. (1980). *Problem-based learning: An approach to medical education*. NY:NY, Springer Publishing Company.

[3] CAIPE. Inter-professional education: A definition. Centre for Advancement of Inter-professional Education, LondonUK 1997.

[4] Canadian Inter-professional Health Collaborative. A National Inter-professional Competency Framework. http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

[5] Clark, P. (2006) What would a theory of Interprofessional Education Look Like? Some suggestions for developing a theorerical framework for teamwork training. *Journal of Interprofessional Care*, 20:6, 577-589.

[6] Clark, P.G., Cott, C. & Drinka, T.J.K. (2007) Theory and practice in interprofessional ethics: A framework for understanding ethical issues in health care teams. *Journal of Interprofessional Care* 21:6, 591-603.

[7] Cooper, H., Carlisle, C., Gibbs, T. & Watkins, C. (2001). Developing an evidence base for interdisciplinary learning: a systematic review. *Integrative Literature Reviews and Meta-Analyses*, 35(2), 228-237.

[8] Daniels, N. (2008). *Just Health: Meeting Health Needs Fairly*. Cambridge, MA: Cambridge University Press.

[9] D'Amour, D., Ferrada-Videla, M., Rodriguez, LSM. & Beaulieu, M-D., (2005). The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. *Journal of Inter-professional Care*, 19(s1), 116-131.

[10] D'Amour D., Oandasan I. (2005a). Interprofessionality as the field of inter-professional practice and inter-professional education: An emerging concept. *Journal of Inter-professional Care*: 19(Suppl. 1)8–20.

[11] D'Eon, M. (2005). A Blueprint for inter-professional learning. *Journal of Interprofessional Care*, 19(2), 49-59.

[12] Dreyfus, E. & Hubert L. Dreyfus, H.L. (1980). *A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition.* Storming Media.

[13] Duncan, M., Alperstein, m. Mayers, P.,Olkers, L. & Gibbs, T. (2006). Not just another multi-professional course! Part 1. Rationale for a transformative curriculum. *Medical Teacher* 28:1, 59-63.

[14] Elgin, C. (1996). The Merits of Equilibrium. *Considered Judgment*. Princeton, NJ.:Princeton University Press.

[15] Frankena, W. (1966). A Model for Analyzing a Philosophy of Education. *High School Journal*, 2, October 12-22.

[16] FHRCO. (May 20, 2009) Who We Are. Federation of Health Regulatory Colleges of Ontario. Available at internet: www.regulatedhealthprofessions.on.ca

[17] Ginsburg, L. & Tregunno, D. (2005). New approaches to interprofessional education and collaborative practice: lessons from the organizational change literature. *Journal of Interprofessional Care*, 19(2), 177-187.

[18] Hall, P. (2005). Inter-professional Teamwork: Professional Cultures as barriers. *Journal of Interprofessional Care*: 19 (Suppl. 1), 188-196.

[19] Harden, R.M. (1998). AMEE guide no. 12: Multi-professional eduation: Part 1:A three dimensional perspective. *Medical Teacher*: 20, 402-408.

[20] Knowles, M. s. (1980). *The modern Practice of adult education: from pedagogy to andragogy*. New York: Cambridge. Adult Education Co.

[21] Kolb, D. A. (1984). *Experiential Learning.* Prentice-Hall. Englewood Cliffs:NJ.

[22] Legare, F., Stacey, D., Graham, I.D., Elwyn, G., Pluye, P., Gagnon, M.P., Frosch, D., Harrison, M.B., Kryworuchko, J., Pouliot, S., & Desroches, S. (2008). Advancing theories, models and measurement for an inter-professional approach to shared decision making in primary care: a study protocol. *BMC Health Services Research*, 8(2), 1-8.

[23] Martin-Rodriguez, L.S.,Beaulieu, M.D., D'Amour, D. & Ferrada-Videla, M. (2005). The determinants of successful collaboration: a review of theoretical and empirical studies. *Journal of Inter-professional Care*, 19(2), 132-147

[24] McDermott,R. & Snyder, W. (2002) *Cultivating Communities of Practice: A guide to managing knowledge.* Harvard Business School Press.

[25] Oandasan I., Reeves S. (2005). Key elements of interprofessional education. Part 2: Factors, processes and outcomes. *Journal of Inter-professional Care*, 19(Suppl.1), 39-48.

[26] O'Neil, P., Iansavitchene, A. & Van Kessel, K. (2007). *Toward a Teaching and Learning Culture in Clinical Practice: Potential Role for the Librarian.* Unpublished.

[27] Pirrie A., Wilson V., Harden R. M., Elsegood J. AMEE Guide No. 12: Multi-professional education: Part 2. Promoting cohesive practice in health care. *Medical Teacher* 1998; 20: 409–416.

[28] Reeves, S., Zwarenstien, M., Goldman., Barr, H., Freeth, D., Koppel, I. & Hammick, M. (2010). The effectiveness of interprofessional education: Key findings from a new systematic review. *Journal of Interprofessional Education*, 24:3, 230-241.

[29] Reeves, S. (2010) Editorial. Ideas for the development of an inter-professional field. *Journal of Inter-professional Care.* 24: 3, 217-219.

[30] Schon, D. (1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith

[31] Schon, D. (1987). *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass, 1987

[32] Sen, A.K. (2009).*The Idea of Justice.* Cambridge, MA: Harvard University Press.

[33] Wenger, E. (1998) *Communities of Practice: Learning, Meaning and Identity*. Cambridge University Press, New York, 1998.

[34] Xyrichis, A., Lowton, K. (2008). What fosters or prevents inter-professional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies*, 45:140–153

[35] Zwarenstein, M., Goldman, J., Reeves, S., (2009). Inter-professional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews.* Issue 3. Art. No.: CD000072. DOI: [10.1002/14651858.CD000072.pub2]

